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Erotic Mindfulness: A Core Educational and Therapeutic Strategy in Somatic Sexology Practices

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Somatic sexology modalities such as sexual surrogacy, sexological bodywork, masturbation coaching, and orgasmic meditation have shown significant potential for helping individuals transcend sexual difficulties and grow into more fulfilling erotic lives. The use of an embodied state of consciousness similar to neo-traditional forms of mindfulness meditation may be a common factor contributing to therapeutic efficacy in a variety of somatic sexology methods. Comparing the structure of three somatic sexology modalities—sexual surrogacy, masturbation coaching, and orgasmic meditation—with recent evidence supporting the efficacy of neo-traditional mindfulness practices in promoting women’s sexual wellbeing reveals that somatic sexology practitioners use embodied mindfulness as a strategy to set aside mental activity and invite their clients to feel, act, and interact with their sexuality from an embodied state of attention. This embodied state, when focused on one’s eroticism and sexuality, will be referred to as *erotic mindfulness*. The paper closes with a commentary on the potentially significant impact of using erotic mindfulness in sex therapy and education, and suggests avenues for further research.

Keywords: *Holistic sexuality, somatic sexology, embodied mindfulness, erotic mindfulness, sexual surrogacy, masturbation coaching, orgasmic meditation, sexological bodywork*

Is there a place for the body in sex therapy? This question titled a 2011 editorial of the *Sexual and Relationship Therapy* journal, as its editor-in-chief Alex Lantaffi pleaded with sex therapists and educators to explore and expand the research evidence for bringing embodied practices back into the therapy room. As he explained,

I have been struck by the possibilities that being present to the body can open up within the therapy room, especially when dealing with sexuality and relational issues. Yet, most of the current literature does not seem to address the applicability of sensorimotor therapy or somatic healing to sex therapy. (Lantaffi, 2011, p. 1)

His voice echoed many others (e.g., Barratt, 2010; Kleinplatz, 1996; Tiefer, 2006; Ventegodt & Struck, 2009) asking that clinical sexology’s “resistance to the humanistic programme [be] addressed” (Tiefer, 2006,

p. 371), both in order for somatic and experiential modalities to reclaim the space they once held, and for them to resume their development within the field.

Indeed, in the 1970s, the popularity of humanistic psychology brought forward great interest in “new forms of psychotherapy (e.g., Rogerian, existential, Gestalt, body- and movement-centered) that focused on growth and fulfillment, unconditional positive regard, staying in the present, feelings and consciousness, and a holistic body-mind view” (Tiefer, 2006, p. 362). This movement supported the advent of many somatic sexology modalities, or *teaching by doing* approaches, such as orgone Reichian therapy (Nelson, 1976), the use of surrogate partners (Wolfe, 1978), and the practices of nudism, body imagery work, and sexual contact with clients (Hartman & Fithian, 1974). These practices involved a spectrum of experiential activities from using nudity to teach

self-acceptance, masturbation coaching, one-way touch from therapist to client, and two-way touch.

The main premise for using somatic modalities in therapeutic settings is that powerful emotions such as shame, guilt, disgust, anger, helplessness, and fear are in some sense stored within the body, particularly in the tissues of pelvic and sexual organs as tension and pain (e.g., Ventegodt, Morad, Hyam, & Merrick, 2004) and therefore often remain out of reach for pharmaceutically oriented cures and talk therapy. Sex therapist Jack Morin (2006) observed, "Some of my clients' issues would take years or might never be resolved by standard non-touching therapy." The therapeutic efficacy of somatic modalities, in contrast, seems to reside in the process of attunement and presence with the body itself; in a safe and ethical context, this process appears to support the release and integration of painful emotions and trauma (Moore, 2017; Ventegodt, Clausen, Omar, & Merrick, 2006). Furthermore, the direct experience of one's eroticism outside of performance expectations and relational narratives habitually associated with sexual contact (e.g., striving to perform specific roles or activities in order to satisfy someone else) can, in itself, be a source of deep freedom, self-discovery, and empowerment (Jesse, 2017). Somatic sex educator Cassie Moore (2017) exemplified this through her own experience of somatic healing with a sexological bodywork practitioner:

I experienced trauma in my early childhood, and despite extensive counseling and a lifetime of attempts to move towards health, I still carried a deep sense of sorrow and brokenness in my body, and a profound sense of shame. . . . Through guided touch, words and presence, I felt a huge, unexpected sense of release of sorrow and shame, and a shifting toward safety and wholeness. . . . I experienced my voiced needs being acknowledged, honored and met, and it was deeply restorative and transformative for me. I know that this level of change would not have occurred in a more traditional therapeutic container. The element of compassionate, safe touch that included my sexual body, guided fully by me, provided a unique and powerful context for repair. (Moore, 2017, pp. 3–4)

This testimonial, along with many others, portrays the non-judgmental witnessing and validation of someone's unscripted erotic expression as key to the therapeutic alliance between somatic sexology educators and clients.

As with most healing modalities involving a strong relational and even spiritual component (e.g., Reiki), somatic sexology practices challenge the general classification and validation structures of the current scientific model. They blur the lines habitually drawn between therapy, education, and spiritual practice by addressing eroticism as a holistic phenomenon, instead of a purely physiological, cognitive, and behavioral one. Also, the experiential and often multifaceted nature of those methods (blending emotional, physical, and spiritual dimensions into erotically-focused practices) challenges the binary between sexual function and dysfunction, which is foundational to the field of sexology (see Masters & Johnson, 1970). Often, clients seek out experiential methods not only to remedy their sexual problems, but also to explore their erotic potentials (Kleinplatz, 1996) and unravel transformation into various aspects of their life, such as improvements in physical health and relationship satisfaction (Resnick, 2004). The fact that somatic sexology modalities are holistic in nature and thus function outside the mainstream medical model of sexual health has resulted in a lack of empirical research in these areas. This, along with the ethical and legal risks associated with sexually-oriented touch (see Tiefer, 2006), brought the American Association of Sexuality Educators, Counselors and Therapists (AASECT) to explicitly ban touching or nudity in treatment in 1978, and professional sex therapy became limited to talk therapy, along with pharmaceutical and behavioral approaches.

However, nudity and touch in sexual therapy and education never entirely disappeared. Today, such practices still exist, however within an ambiguous legal and professional framework. For example, sexual surrogacy, sex and masturbation coaching, and various erotic embodiment workshops remain available to the public, though they are not reimbursed by medical insurance plans as their pharmaceutical and cognitive-behavioral counterparts often are—thereby restricting their

reach to small, economically privileged audiences. Therefore, there is a compelling need to look at somatic sexology through an expanded scientific lens that privileges therapeutic efficacy over culturally based assumptions around sexuality.

Modes of sexual therapy and education vary widely across nations and cultures (e.g., Wylie & Weerakoon 2010), and there is much to learn from countries where certain somatic modalities are more commonly viewed as legitimate practices, such as Israel, where sexual surrogacy is legal and accepted (Rosenbaum, Aloni, & Heruti, 2014). Additionally, while empirical research on somatic sexology modalities is sparse in the United States at this time, there is a growing body of scientific literature from Denmark supporting the use of those modalities to address a wide range of sexual problems in clinical settings. Practices involving genital touch from practitioners, such as *acceptance through touch* and *vaginal acupressure*, have been shown to help patient with sexual pain disorders, vulvar vestibulitis syndrome, vaginismus, and dyspareunia (Ventegodt et al., 2006; Ventegodt & Struck, 2009), vulvodynia (Ventegodt et al., 2004), and even severe anxiety linked to sexual abuse in childhood (Ventegodt, Clausen, & Merrick, 2006). Additionally, Danish researchers have found masturbation coaching to be highly efficacious in helping women suffering from anorgasmia. In a study conducted with a sample of 500 anorgasmic women in Denmark, 93% of participants experienced success in achieving orgasm through masturbation coaching (see more detailed presentation of the study on p. 8; Struck & Ventegodt, 2008).

Understanding what makes such practices potentially healing and transformative may support further research in these areas. A nascent strand of empirical research on embodied mindfulness, including a series of studies connecting mindfulness practice with sexual satisfaction in women, suggests that the state of attention associated with the practice of embodied mindfulness might be the core experience that yields efficacy to somatic sexology methods in fostering transformation and healing. Juxtaposing recent evidence of the efficacy of neo-traditional mindfulness-based stress reduction techniques (MBSR; e.g., Kabat-Zinn, 2003a, 2003b)

in controlled clinical studies with the structure of several somatic sexology practices (including non-clinical ones), it appears that somatic sexology practitioners use a process similar to embodied mindfulness as a strategy to set aside mental activity and invite their clients to feel, act, and interact with their sexuality from an embodied state of attention that can be described as *erotic mindfulness*.

In the following section, pertinent literature on the effects of embodied mindfulness practice is reviewed, including that which relates specifically to sexual function and arousal. Then, three categories of somatic sexology practices—sexual surrogacy, masturbation coaching, and orgasmic meditation—are described and shown to rely on the working principle of erotic mindfulness.

Embodied mindfulness

Many definitions of the terms *embodiment* and *mindfulness* exist in the psychological literature (e.g., Glenberg, 2010; Schubert & Semin, 2009). In this paper, embodied mindfulness is defined from the perspective of somatic phenomenology. Somatic phenomenology as described by Hartelius (2007, 2015) has depicted states of consciousness in relation to one's *attentional posture*—referring to where the attention is felt to be *coming from* within the body of the subject (i.e., their egocenter), rather than what the subject's attention is *pointing at*. The premise is that one's state of consciousness is affected by where one's attention is coming from (e.g., the head, the heart, or the lower belly) as well as by other dimensions of their attentional stance (e.g., whether diffused or focused) in the body. Thus, the definition of embodiment used in this paper refers to a state where one's attentional activity originates *from the core of the body*, rather than from the forehead—or in Hartelius and Goleman's (2016) words,

those states of consciousness in which the attention that normally arises from the head is now deployed from the central structures of the body—as if the self that is conventionally centered in the head is now located in the trunk of the body. (p. 167)

The aforementioned principles are then used

to distinguish between two varieties of mindfulness practices (Hartelius, 2015): cognitive-behavioral (e.g., Hayes, Strosahl, & Wilson 2011) and neo-traditional, exemplified by Kabat-Zinn's (2003a, 2003b) mindfulness-based stress reduction (MBSR). The former reflects a state of awareness where the mind harnesses its attention to promote a disidentification from mental contents while the egocenter remains seated in the head, using strategies based on language, thought, and perspective taking (Hartelius, 2015), and the latter reflects a *radically embodied* stance (Hartelius & Goleman, 2016), where a consciousness shift occurs by shifting the egocenter downward so that attention is experienced as coming from the belly and/or the trunk of the body instead of from the head. The working principle of embodied mindfulness (which is used interchangeably with the term *neo-traditional mindfulness*) is thus a shift of consciousness where

the observer of thoughts, emotions, and sensations is not the familiar ego but a moment-to-moment awareness focused on the experience that is present to the senses (cf. Kabat-Zinn 1990) rather than the conventional narrative of a historical self. In this state, insight arises not from cognitive reflection but from non-conceptual noticing. (Hartelius, 2015, p. 1273)

The effects of embodied mindfulness

Embodied mindfulness has been the recent subject of much empirical study. Over the last few decades mindfulness has been increasingly viewed as a central process in therapeutic change (Baer, 2003; Grossman, Niemann, Schmidt, & Walach, 2004; Martin, 1997). More specifically, therapies based on MBSR have been shown to be helpful in the treatment of many medical, psychological, and behavioral ailments (Grossman et al., 2004; Merkes, 2010) as well as positively affect physiological health (e.g., Teixeira, 2008) and epigenetic changes (Bhasin et al., 2013; Kaliman et al., 2014; see also Brotto & Basson, 2014). Indeed, several meta-analyses have shown MBSR-based practices having a positive impact in a range of clinical and non-clinical interventions, such as the treatment of depression and anxiety across populations with a chronic medical disease (Bohlmeijer, Prenger, Taal, & Cuijpers, 2010; Cramer,

Lauche, Paul, & Dobos, 2012; Hofmann, Sawyer, Witt, & Oh, 2010), the physical and psychological support of patients struggling with chronic pain (Teixeira, 2008), and the stress management of healthy people (Chiesa & Serretti, 2009).

These desirable effects could be attributed, at least in part, to mindfulness' positive impact on empathic response and presence. In 2007, Block-Lerner and her colleagues demonstrated that MBSR approaches can play a role in the cultivation of empathy, arguing that non-judgmental, present-moment awareness increases the capacity for perspective-taking and empathic concern (Block-Lerner, Adair, Plumb, Rhatigan, & Orsillo, 2007). They explained:

As individuals are more mindfully attentive to the thoughts and feelings they and others experience in the present moment, they are more likely to find common ground and greater intimacy in their relationships, engage in higher levels of valued action, and increase their overall quality of life in the process—one moment at a time. (p. 513)

Indeed, it appears that exercising a more embodied attentional posture, characteristic of a state of embodied mindfulness, may facilitate a quality of in-the-moment presence that, in turn, enhances one's ability for empathic resonance and attunement.

Predictably, research also shows that MBSR-inspired embodied mindfulness practices can improve one's sexual functioning. Brotto and Basson (2014) investigated the effects of a mindfulness-based cognitive behavioral sex therapy (MBCST) training on women ($N = 115$) seeking treatment for distressingly low or absent sexual desire and/or sexual arousal. In their study, women participated in group sessions that included mindfulness meditation, cognitive therapy, and psychosexual education. The treatment also included many somatic practices, either performed on site or as homework, that were strikingly akin to the humanistic somatic sexology modalities developed in the 1960s. Each treatment session included a mindfulness practice component. In session 1, mindfulness was introduced through a body scan, a practice where participants were guided to notice different parts of the body while tuning into

the sensations without attempting to change them. In Session 2, the body scan was repeated, this time with attention on the genital areas. Women were invited to use a hand-held mirror to look at their own genitals as part of the practice, and reminded to remain in a state of embodied, non-judgmental attention. In session 3, women were encouraged to repeat the body scan that included genital focus, but this time incorporating some light touch to focus on the sensations that arise with touch. This was framed as a “non-masturbatory exercise designed to continue the mindfulness and non-judgmental awareness of the genitals and not meant to elicit sexual arousal” (Brotto & Basson, 2014, p. 46). In the final (4th) session, therapists introduced the practice of *sensate focus* (see Masters & Johnson, 1966, 1970) to be used at home with a partner, or in a visualization of how they might use *sensate focus* with a future partner (Brotto & Basson, 2014). This treatment significantly improved sexual desire, sexual arousal, lubrication, sexual satisfaction, and overall sexual functioning in the women participants (Brotto & Basson, 2014).

Building on previous findings suggesting that mindfulness could promote a more direct access to body sensations by training attention and reducing negative self-evaluation (Brotto, 2013; de Jong, 2009), the authors had hypothesized that “mindfulness practices can not only increase awareness of sexual responses unfolding moment by moment, but also lessen judgment that the latter are insufficiently intense or in some way sub-standard” (Brotto & Basson, 2014, p. 44)—a proposition that was confirmed in their results. Also, they found that women practicing *non-judgment* in a sexual context experienced less self-judgment as well as higher acceptance of the partner and sexual context, which are all positive predictors for desire and arousal. Additionally, this study suggested that mindfulness training may have “tempered the anxiety, guilt, self-criticism, and frustration that may preclude women’s arousal from sexual stimuli” (Brotto & Basson, 2014, p. 51).

Those findings corroborate the growing empirical literature showing the beneficial effects of mindfulness-based treatment for sexual difficulties in women (e.g., Gunst et al., 2018; Velten, Margraf,

Chivers, & Brotto, 2018; see Stephenson & Kerth, 2017 for a meta-analytic review and endnote 1 for a more comprehensive list)¹, in men (Bossio, Basson, Driscoll, Correia, & Brotto, 2018), and in both men and women (Kimmes, Mallory, Cameron, & Köse, 2015; Sommers, 2013). While those approaches do not involve touch between patients and practitioners, they bring scientific support and legitimacy to the use of somatic and experiential approaches in addressing sexual difficulties by virtue of successfully employing erotic mindfulness as a core principle of sexual healing and transformation.

Further corroborating the clinical evidence for mindfulness practice’s enduring benefits on cognition and behavior are neuroscientific studies showing brain changes in individuals who practice mindfulness meditation. Mindful presence has been shown to have effects on a person’s brain activity that leads not only to temporary, limited behavioral change, but also to larger and multifaceted change (Baldini, Parker, Nelson, & Siegel, 2014). It is known from studies in neuroplasticity that how one learns to focus the mind can alter the structure of the brain (Siegel, 2009). Siegel (2010a, 2010b) demonstrated that clinicians can promote their clients’ wellbeing by supporting neural integration through the practice of mindfulness. Mindfulness has been shown to effectively alter the top-down habitual activity of the brain cortex’s upper layers by allowing the ongoing sensory experiences flowing from its lower layers to take charge of one’s attention. While upper layers 1, 2, and 3 represent the conceptual and linguistic mental categories that one constructs from past experiences, lower layers 6, 5, and 4 bring up fresh, unscripted, and non-judged sensory information to awareness (Siegel, 2009). The upper layers’ role in interpreting and categorizing fresh input from the bottom layers is undeniably useful in everyday adult functioning, but it also constrains and deprives the mind from its natural sense of liveliness, vitality, and freedom that is typically experienced in both infancy and in genuinely surprising or novel situations. Thus, the habitual intrapersonal cortical oppression of layers 1, 2, and 3 can leave one’s awareness “imprisoned by prior learning” and adults feeling “dead inside” (Siegel, 2009, p. 154), while on the other hand,

mindfulness practice brings “a breath of fresh air. . . into our lives” (Siegel, 2009, p. 154).

More recently, Tang, Hölzel, and Posner (2015) conducted a meta-analysis of the previous two decades of mindfulness literature to describe to what extent previous research had revealed changes in brain activity and brain structure following mindfulness meditation training. Because the studies reviewed varied in terms of research design, measurement and type of mindfulness meditation used, the locations of reported effects varied across multiple regions in the brain. Further, effects were reported in multiple brain regions at once, suggesting that the effects of mindfulness might involve large-scale brain networks. Nevertheless, eight brain regions were found to be consistently altered in meditators. To demonstrate this, Fox et al. (2014) reviewed and meta-analyzed 123 brain morphology differences from 21 neuroimaging studies, reflecting a total sample size of approximately 300 meditation practitioners. They found increases in structures of the following regions: the frontopolar cortex, which is suggested to be related to enhanced meta-awareness following meditation practice; the sensory cortices and insula, areas that have been related to body awareness; the hippocampus, a region that has been related to memory processes; the anterior cingulate cortex (ACC), mid-cingulate cortex and orbitofrontal cortex, areas known to be related to self and emotion regulation; and the superior longitudinal fasciculus and corpus callosum, areas involved in intra- and inter-hemispherical communication (Fox et al., 2014).

The connection between brain maturation (observed as structural increases of brain regions) and cognitive development is well established, and there is robust evidence in favor of the brain structure-function connection in human neuroimaging. This points to the idea that mindfulness practice promotes healthier brain function by reinforcing the structures of the eight brain regions listed above. However, it bears mentioning that the morphometric neuroimaging field as a whole, and the smaller realm involving meditation practitioners in particular, is as yet in early stages of understanding the specific meaning of brain structure differences. Low replication rates also point to the need for further

research to corroborate those preliminary findings. Nevertheless, the authors suggested that “brain structure increases related to meditative practice might provide at least a partial neural explanation of the numerous cognitive and emotional benefits associated with meditation” (Fox et al., 2014, p. 52).

This preliminary evidence, while still nascent, supports anecdotal data arguing that somatic sexuality modalities may create lasting and positive changes in a person’s wellbeing. If those modalities evoke a state of embodied mindfulness in individuals who practice them, it would likely follow that those practices alter not only their brain activity in the moment, but also affect their brain structure of in lasting and desirable ways.

Somatic-Experiential Therapies

Somatic sexuality modalities, as well as at the Somatic components of Brotto and Basson’s (2014) mindfulness-based cognitive behavioral sex therapy (MBCST), are both structurally akin to the practice of embodied mindfulness—and seem to yield results similar in nature to those that mindfulness brings in non-sexual therapeutic settings such as the ability to experience increased in-the-moment presence, non-judgmental awareness, as well as empathic resonance and attunement. Indeed, sexual arousal as a portal for pleasure is a compelling draw to stay present in the moment: Erotic sensations provide a fitting basis for the practice of embodied mindfulness, and reclaiming a more unhindered connection to the cortical bottom-up information flow appears to enhance erotic sensation (Sommers, 2013)—thus offering a way for somatic sexuality to naturally promote vitality and wellbeing in the sexual arena. This will be exemplified with the analysis of three somatic sexuality modalities: surrogate partner therapy, masturbation coaching, and orgasmic meditation.

Surrogate Partner Therapy

Surrogate partner therapy is far from a new technology, as it reflects in many ways the work of sacred prostitutes in ancient cultures (Qualls-Corbett, 1988) of engaging in two-way sensual touch for the purpose of somatic, emotional, and sexual healing. The term *surrogate partner* was coined in the late 1960s and early 1970s by sex therapy

pioneers Masters and Johnson (1966, 1970), who introduced volunteer partner surrogate therapy into their work as a way to help their single patients with sexual dysfunctions calm debilitating performance pressures (Morin, 1995). As the practice grew in popularity, many surrogate volunteers were trained, all of whom were licensed professionals: it was these professionals who later formed the International Professional Surrogates Association (IPSA) and developed a detailed code of ethics for members, in order to compensate for their ambiguous legal status (Bullough & Bullough, 1994).

Guided by these ethics, certified surrogates must be supervised by a therapist, as part of a three-way therapeutic team, in order to work with a client (Poelzl, 2011). A sexual surrogate is a practitioner “with whom the client practices, role-plays, and rehearses skills taught by the therapist during their sessions. The surrogate provides feedback to the client on their behaviors while the [surrogacy] session is in progress” (Rosenbaum et al., 2014, p. 323). The role of surrogates is to somatically guide clients to experience a fuller range of sexual expression using sensate present moment awareness, with goals ranging from curing specific sexual dysfunction, to enhancing relational intimacy, to exploring uncharted erotic potentials (Poelzl, 2011). During the therapy process, a weekly meeting is held between the therapist and the client, between the therapist and the surrogate and, only then, between the surrogate and the client. At the end of the therapy process the relationship between the client and the surrogate is completely terminated (Aloni & Heruite, 2009).

In addition to its use as adjunct to sex therapy, sexual surrogacy is increasingly seen as a way to help people with disabilities live sexually vibrant lives and build sexual self-esteem (Shapiro, 2002). Indeed, cultural perceptions of sexual attractiveness and desirability, often combined with other barriers such as physical limitations, can make sexual access to intimate partners through traditional routes highly challenging for disabled people (Shuttleworth & Mona, 2002). As health professional and activists are increasingly recognizing the inherent sexuality of disabled persons and attempting to find ways to accommodate their needs (Appel, 2010), professionally facilitated intimacy can be an integral

part of a whole-person framework of patient-centered care (Earle, 2002). Sexual intercourse is said to have a “minimal presence in the types of sexual services normally provided to the patient” (Shapiro, 2002, p. 76), and the goal of the practice is not exclusively to achieve climax. Instead, “the ultimate benefit of this type of therapy is to increase the sexual self-esteem of the disabled person through the physical pleasure of non-penetrative bodily contact and to help the disabled person learn about their own body” (Shapiro, 2002, p. 76).

The backbone of a surrogate partner’s practice, developed by Masters and Johnson (1966, 1970), is called the *sensate focus* method of sensual touch with verbal feedback. This method can be defined as the surrogate directing the client’s attention away from their heads and into the concrete world of the senses (Morin, 1995). This also contributes to moving a client away from *spectatoring*—described by Masters and Johnson (1970) as a person focusing on himself or herself from a third person perspective during sexual activity, rather than focusing on one’s sensations and/or sexual partner—a cognitive distraction that could increase performance fears and cause deleterious effects on sexual performance (see Trapnell, Meston, & Gorzalka, 1997). Thus, sensate focus is more of an attitude about touch rather than a specific behavior, where partners remain in a neutral state of exploration and experimentation while giving and receiving touch (Weiner & Avery-Clark, 2014).

Brotto and Basson (2014) argued that the sensate focus method was in fact a variety of embodied mindfulness practice:

In their description of the causes of sexual dysfunction, Masters and Johnson (1970) believed that anxiety and spectatoring played a major role for both women and men, and developed sensate focus as a core aspect of therapy. Sensate focus involved the structured and progressive touching by one partner to the other as a means of improving concentration on the sensual aspects of touch and to reduce anxiety. Although Masters and Johnson did not use the term mindfulness, in part, cultivating mindfulness [sic]. However, rather than any

focus on acceptance of the present moment, during sensate focus each partner is encouraged to give on-going feedback and guidance so as to find the optimal type of stimulation. (p. 44)

Sensate focus was also said to be an especially helpful tool for enjoying a sexual experience when one would be “in the gray zone, unsure of what to do next” (Morin, 1995, p. 245). Thus, it seems that sensate focus is, at core, a form of embodied mindfulness practice focused on erotic content.

Masturbation Coaching

Masturbation coaching, or directed masturbation, is a form of therapy that was developed in the early 1970s as a behavioral treatment for female orgasmic disorder (Both & Laan, 2008). Based on the concept of sensate focus introduced by Masters and Johnson (1966, 1970), LoPicollo and Lobitz (1972) were the first to design a multi-step masturbation program for anorgasmic women, which included both partners of a couple. This program consisted of education, self-exploration and body awareness, directed masturbation, and sensate focus. Later, Barbach (1974, 1975) transformed the masturbation program to a format for group treatment for women without their partners. More recently, Betty Dodson (1996, 2002), a well-known sex coach and educator, became famous as a masturbation coach working with clients individually as well as in group experiential workshops for women called *Bodysex*TM (Britton & Bright, 2014). *Bodysex*TM consists of a two-day workshop, five hours each on a Saturday and Sunday afternoon, where about ten women are in attendance and participate in nude group sessions throughout the entire workshop (Meyers, 2015). Dodson (2005) described her methods:

During a sex coaching session, we view her genitals under a bright light naming all the parts and locating the clitoris. She takes her first steps in developing positive genital self-esteem. She locates and feels the pubococcygeal (PC) muscle with her finger inside her vagina. Lying down, she experiences slow vaginal penetration under her control while using a well-lubricated resistance device. While she squeezes and releases the PC muscle she adds pelvic rocking

and coordinates her breathing. Next she uses different methods of stimulating her clitoris: manual masturbation, a small battery vibrator and two electric vibrators of varying intensities. While she masturbates, I observe and encourage her to go beyond current boundaries of tolerating intense pleasurable sensations. Sex coaching heals her confusion about orgasm. (p. 43)

Two studies have investigated the effectiveness of Betty Dodson’s methods of masturbation coaching. One study was conducted in Denmark with a sample of 500 anorgasmic women, between 18 and 88 years of age (mean of 35 years) with chronic anorgasmia (for 12 years on average). Of the participants, 17% claimed that they had been sexually abused in childhood, and 25% had never experienced an orgasm. They participated in the “orgasm course for anorgasmic women” (p. 886), which included three therapy sessions of five hours each. The sessions used the tools of reparenting, genital acceptance, acceptance through touch, and direct sexual clitoral stimulation aiming to entice sexual and existential healing (salutogenesis). The treatment included patient masturbation under supervision and instruction using a clitoral vibrator after initial digital stimulation. The therapist, Pia Struck, co-chair of the Danish Association for Sexology, was trained in psychodynamic psychotherapy and had 10 years of professional experience with the treatment of sexual dysfunctions at the time of the study. Her training was also supplemented with personal sexological training by Betty Dodson in 2001. Of the patients, 50 were treated individually (one-on-one) because they felt uncomfortable participating in the group sessions. Results showed that 465 patients (93%) had an orgasm during therapy, witnessed by the therapist, and 35 patients (7%) did not. No patients had detectable negative side effects or adverse effects (Struck & Ventegodt, 2008).

Meyers (2015) also studied the impacts of masturbation coaching by assessing the impact of participation in Betty Dodson’s *Bodysex*TM workshops in women, on different aspects of their sexuality: sisterhood, masturbation, orgasm, sexual

self-schema, body esteem, and female genital self-image. She used a mixed-method research design to find “to what degree and in what ways does change result” from participation in Bodysex™ workshops (Meyers, 2015, p. x). Surveys from 63 prior participants provided quantitative data while individual interviews with a volunteer sample of 15 of those women provided qualitative data. Thirteen women also participated in pre/post surveys. The exploratory design of this study went beyond the binary purpose of assessing the achievement of climax (or not), and rather focused on the participants’ perceptions of their transformative experiences resulting from the workshop. The study thus yielded nuanced and detailed results, and readers are referred to the original text (Meyers, 2015) to fully grasp the complexity of the three participant pools’ responses. Nevertheless, statistically significant changes regarding genital self-image, sexual efficacy, and sexual satisfaction were found from quantitative data, and four main themes emerged from the qualitative interviews and open-ended survey questions: (a) *Experience of sisterhood*: described as bonding/connection, and female connections at home; (b) *Feeling more normal* as related particularly with: nudity, their genitals, their sexual satisfaction and sexual-esteem, and common struggles; (c) *Feeling empowered*: through increased knowledge and competency and self-permission to pursue life changes in their primary relationships; (d) *Healing*: emotional healing from past trauma, shame, and guilt and physical healing from specific conditions (Meyers, 2015, p. 97).

Directed masturbation is one of the only somatic sexology modalities to have remained recognized and endorsed by mainstream clinical science, partly because it is used to target a specific type of sexual dysfunction, described in the DSM-IV as female anorgasmia, and partly because it has the ethical advantage of not necessitating the touch of a therapist. Both and Laan (2008) assessed that “reviews of treatments for sexual dysfunctions in women that follow the criteria for validated or evidence-based practice (APA, 1995) conclude that directed masturbation treatments for primary anorgasmia fulfill the criteria of ‘well established,’ or at least ‘probably efficacious’” (p. 159).

To what does directed masturbation owe its efficacy? Once again, it appears that erotic mindfulness lies at the core of the practice:

The exercises [prescribed in directed masturbation] focus initially on body awareness and body acceptance, and on visual and tactile exploration of the body. Second, women are encouraged to discover the areas of the body that produce pleasure when touched. After that, women are instructed in techniques of masturbation, and to use fantasy and imaging to increase sexual excitement. The use of topical lubricants, vibrators, and erotic literature or videotapes is often recommended. Frequently, Kegel exercises (contraction and relaxation of the pelvic floor muscles; Kegel, 1952) are prescribed, since they may increase women’s awareness of sensations in the genitals and because that may enhance sexual arousal. (Both & Laan, 2008, p. 159)

This treatment description is strongly reminiscent of Brotto and Basson’s (2014) sexual mindfulness treatment. In both cases, sensate focus—or the focused attention gradually placed towards bodily sensations—is the main working principle. Both methods address negative scripts and emotions around sexuality using additional cognitive-narrative avenues, but these appear to fulfill a supportive role: the crux of these practices is experiential sensate awareness, which ultimately aims to disentangle sexual pleasure from judgmental and narrative content. This is performed by encouraging participants to shift into a state of presence within their bodies, and to immerse themselves into erotic sensations.

While directed masturbation methods were developed specifically to address anorgasmia in women, masturbation coaching is also used with men. In those cases, the focus is usually not on achieving climax, but rather on feeling more pleasure, accessing altered states of consciousness, gaining enhanced orgasmic and ejaculatory control, and weaving the heart to the genitals (OrgasmicYoga.com). Joseph Kramer, who founded the *Body Electric School* and the *New School of Erotic Touch*, employs masturbation coaching extensively as a

form of erotic mindfulness training in his programs. Specifically, his *Orgasmic Yoga Institute* (an offshoot of the New School of Erotic Touch) includes a *Mindful Masturbation* program for men that offers “clear and simple instructions to escape from habit and enjoy embodied masturbation” (OrgasmicYoga.com). Unfortunately, no peer-reviewed literature addresses this specific practice as yet; however, its practices are coherent with the principle of erotic mindfulness.

Orgasmic Meditation

Orgasmic Meditation (OM) is a sexual mindfulness practice where a partner of either gender gently strokes a woman’s clitoris for 15 minutes with no other goal other than to feel, connect, and be present (OneTaste, 2019). OM was popularized by Nicole Daedone, who founded the OneTaste organization and conducted workshops based on the practice in several cities around the United States (Snyder, 2013). In *Slow Sex: The Art and Craft of the Female Orgasm*, Daedone (2011) explained:

In Orgasmic Meditation we learn to shift our focus from thinking to feeling, from a goal orientation to an experience orientation. This shift turns all our expectations about sex on their head, exchanging “faster” and “harder” for “slower” and “more connected.” (Kindle location 171)

The practice of cultivating embodied attention using the contact between finger and clitoris as a focal point is very much akin to other mindfulness practices, both sexual and non-sexual. By isolating focus on the sensation, orgasmic meditators disassociate sexual pleasure from traditional performance goals and show confidence in the ultimate wisdom of the body (Snyder, 2013).

Orgasmic meditation is said to enhance practitioners’ sense of vitality in the rest of their lives, including their day-to-day sex lives by inducing a deeper sense of intimacy and an attention to the foundation of pleasure, free from agendas or relational expectations (Daedone, 2011). Millar (2015), a coach for OneTaste, conducted a survey for her master’s thesis exploring the demographics of people who practice OM and the reported

benefits. For this survey, 419 participants were split nearly evenly between male and female with five responding as transgender or other. Ages ranged from 18 to over 75. Millar asked them to rate the effect of OM on their intimate romantic partnerships, familial relationships, friendships, health, mental health, professional life and spiritual/religious life. In terms of their intimate partnerships, both men and women generally reported that the practice of OM resulted in “improvements of their sex lives, communication, awareness of others, as well as increased their sensation and ability to feel, and self-confidence” (pp. 31–32). Millar’s position as an organization insider as well as her convenience sampling method may have affected her research results. It is likely that her recruiting and interviewing processes offered cues to participants about what the researcher hoped to hear, so the results should be interpreted critically.

However, OM’s similarity in structure to other sensory-based mindfulness meditations is so striking that similar beneficial effects should naturally be expected. OM is fundamentally a specialized version of the sensate focus method developed by Masters and Johnson (1970): it shifts the attention away from mental activity and performance expectations, and turns it towards the body’s moment-to-moment sensation for both stroker and strokee. As such, the practice exemplifies the core principle of erotic mindfulness.

Discussion

There are additional somatic sexuality modalities that could have been included in this short review of clinical applications of erotic mindfulness, but the focus here is on examining what makes those practices effective. Just as neo-traditional or embodied forms of mindfulness have shown durable efficacy in helping practitioners move beyond trauma to more fulfilling lives (e.g., Siegel, 2009), erotic mindfulness may catalyze the healing journeys of individuals facing a wide spectrum of sexual concerns and trauma, as well as enrich the lives of those who are seeking a more expansive, embodied, and empowering relationship with their sexual and erotic nature. There is abundant anecdotal evidence (e.g., Blackburn, 2011;

Jesse, 2017; Moore, 2017) and growing empirical evidence (e.g., Meyers, 2015; Struck & Ventegodt, 2008) that characterizes the field of somatic sexology as a highly promising avenue of practice for sexual education and healing. The limitations of talk therapy and medication for treatment of psychologically related sexual challenges are well documented (Moore, 2017; Morin, 2006; Resnick, 2004; Tiefer, 2006), and it appears that somatic and experiential modalities could be instrumental to the progress of the sexology field.

While the ethics of touch are complex, and thus difficult to regulate (Barratt, 2010; Ventegodt & Struck, 2009), this alone should not stop the scientific community from investigating these avenues. For one, the attitudes of the scientific and therapeutic communities are contingent on larger cultural assumptions and value orientations towards sexuality itself. While collective attitudes and assumptions around the topic of sexuality tend to transform slowly, there is opportunity for practitioners in the field of sexology to incorporate erotic mindfulness as a potential common mechanism within promising therapeutic approaches. Tiefer's (2006) plea is still pertinent over a decade later:

[I]t seems likely that resistances to the use of bodywork or group-work or political action on the part of sexologists arose from the desire to adhere to the most respectable approaches so as to establish the legitimacy of the profession. This in turn may have arisen out of embarrassment about sex itself, especially about the respectability of sexual pleasure rather than sexual function as a focus for work. But in 2006 it is no longer acceptable for professionals in the field of sex education, research and therapy to fear being tainted by the subject matter. Our role is to advocate sexual authenticity and sexual entitlement without hiding behind the medical model of sexual 'health' and 'normality.' (p. 371)

Of course, diving into a sensate experience is not always desirable, or even possible. In cases where a person carries prominent sexual trauma, sexual arousal and pleasure might

initially be associated with painful emotions (Morin, 1995)—causing a person to want to flee sensation. Individuals who display resistance to embodiment might be better served by preparatory psychotherapy to support further healing (Barratt & Rand, 2003). Nevertheless, there are situations where somatic practices can be an effective way to address sexual trauma. Pioneering somatic sex educator Caffyn Jesse (2017) discussed this topic:

For survivors of sexual abuse and violence, navigating desire and communicating choice in highly-charged sexual exchanges can feel impossible. Somatic sex education provides an arena in which people receiving touch can stay safe and focused. They are encouraged to breathe into body sensation and decide, moment to moment, what their body wants. . . . The clear boundaries and ethics of professional practice create a container for healing. (Jesse, 2017, p. 9)

As with traditional modalities, what constitutes an appropriate intervention or practice for each individual must be assessed carefully from both the practitioner's and the client's perspectives. This further highlights the need for science-based protocols to be developed in support of those practices, as well as established professional frameworks.

To fill this need, professional associations have been put in place to provide training programs, standards of certification, and a clear code of ethics to practitioners. For example, the International Professional Surrogates Association offers training and certification for sexual surrogates, as well a code of ethics. The Association of Certified Sexological Bodyworkers fulfils a similar purpose when it comes to sexological bodywork, although there are now several different training organizations that provide education in this modality—the Institute for the Study of Somatic Sexology, the Sea School of Embodiment, and the Institute of Somatic Sexology being some of the most well-known. The Somatic Sex Educators Association and the Association of Somatic & Integrative Sexologists also work to provide training, certification, community, and ethical standards to practitioners.

While these organizations are steadily shaping and strengthening the future of the somatic sexology field, more evidence-based research is needed for those practices to be understood more deeply and become accessible to all the individuals who can reap their benefits. Considering the multifaceted and often central role sexuality plays in people's identity development, relationships, and health, the quest to understand and promote sexual wellbeing cannot be reduced to a single field of inquiry. Elucidating and mapping the emerging field of somatic sexology will require researchers and practitioners alike to adopt a holistic lens that honors the complexities of the lived experience of sexuality and holds space for the potential of healing and transformation. To this aim, scholars from the fields of whole-person psychology (such as somatic, transpersonal, and humanistic), sex science and therapy, medicine and neuroscience need to work collaboratively rather than in isolation—a proposition that has the potential to deepen the understanding of human embodiment as well as cultivate growth and healing in countless lives.

Note

1. The growing body of empirical literature documenting the benefits of using mindfulness-based interventions to address women's sexual difficulties also includes (but may not be limited to): Bober, Recklitis, Bakan, Garber, and Patenaude, 2015; Brotto, Basson, Carlson, and Zhu, 2013; Brotto, Basson, and Luria, 2008; Brotto, Basson, Smith, Driscoll, and Sadownik, 2015; Brotto, Basson, et al., 2008; Brotto, Chivers, Millman, and Albert, 2016; Brotto, Dunkley, et al., 2017; Brotto, Erskine, et al., 2012; Brotto and Heiman, 2007; Brotto, Heiman, et al., 2008; Brotto, Krychman, and Jacobson, 2008; Brotto, Seal, and Rellini, 2012; Dickenson, Allay, and Diamond, 2019; Dunkley and Brotto, 2016; Hocaloski, Elliott, Brotto, Breckon, and McBride, 2016; Hucker and McCabe, 2014; Paterson, Handy, and Brotto, 2017; Rosenbaum, 2013; and Silverstein, Brown, Roth, and Britton, 2011.

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